(2) According to the following fee-for-service schedule for Home-Visiting Services.

Description	Fee Per Unit of Service
Home-Visiting Services	$70

Reimbursement Methodology for Enhanced Services for Pregnant and Postpartum Recipients

A. Request for Payment.

(1) Requests for payment of Healthy Start Program services rendered and completed shall be submitted by an approved provider according to procedures established by the Department of Health and Mental Hygiene. Payment requests which are not properly prepared or submitted may not be processed, but shall be returned unpaid to the provider.

(2) Requests for payment shall be submitted on the invoice form specified by the Department of Health and Mental Hygiene. A separate invoice shall be submitted for each participant. The completed form shall indicate the:

(a) Date or dates of service;

(b) Participant's name and Medical Assistance number;

(c) Provider's name, location, and provider number; and

(d) Nature, unit or units, and procedure code or codes of covered services provided.

(3) Providers shall bill the Medical Assistance Program for the appropriate fee specified in Section C below.

B. Billing Time Limitations.

(1) The Department of Health and Mental Hygiene shall not pay for claims received by the Medical Assistance Program for payment more than 6 months after the completed service date.

(2) Claims for services completed on different dates and submitted on a single form shall be received by the Medical Assistance Program within 6 months of the earliest completed service date.

(3) A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Medical Assistance Program within the original 6 month period, or within 60 days of rejection, whichever is later.

Reimbursement Methodology for Enhanced Services for Pregnant and Postpartum Recipients

C. For professional services rendered by a physician, certified nurse-midwife, nutritionist, home visiting provider, and certified outpatient alcohol and drug abuse program, reimbursement will be the lower of:

(1) The provider's customary charge to the general public;

(2) The Department's fee schedule.

Reimbursement Methodology for Targeted Case Managment for High Risk Infants and Children:

A. Request for Payment

(1) Requests for payment of Healthy Start Program services rendered and completed shall be submitted by an approved provider according to procedures established by the Department of Health and Mental Hygiene. Payment requests which are not properly prepared or submitted may not be processed, but shall be returned unpaid to the provider.

(2) Requests for payment shall be submitted on the invoice form specified by the Department of Health and Mental Hygiene. A separate invoice shall be submitted for each participant. The completed form shall indicate the:

(a) Date or dates of service;

(b) Participant's name and Medical Assistance number;

(c) Provider's name, location, and provider number; and

(d) Nature, unit or units, and procedure code or codes of covered services provided.

(3) Providers shall bill the Medical Assistance Program for the appropriate fee specified in Section C below.

B. Billing Time Limitations

(1) The Department of Health and Mental Hygiene shall not pay for claims received by the Medical Assistance Program for payment more than ~~6~~ 5 months after the completed service date.

(2) Claims for services completed on different dates and submitted on a single form shall be received by the Medical Assistance Program within ~~6~~ 5 months of the earliest completed service date.

(3) A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Medical Assistance Program within the original ~~6~~ 5 month period, or within 60 days of rejection, whichever is later.

C. **Payments shall be made:**

(1) Only to a qualified provider for covered services rendered to a participant, as specified in this state plan amendment; and

(2) According to the following fee-for-service schedule for Home-Visiting Services.

Description	Fee Per Unit of Service
Home-Visiting Services	$70

Recovery and Reimbursement.

A. If the participant has insurance or if any other person is obligated either legally or contractually to pay for, or to reimburse the participant for, any services covered under these regulations, the provider shall seek payment from that source first. If payment is made by both the Medical Assistance Program and the insurance or other source, the provider shall report, within 15 days after the close of each month, on a form designated by the Department of Health and Mental Hygiene, the amount paid by the Medical Assistance Program, and the insurance or the other source, whichever is less, and refund the total amount of the lesser of the two payments reported to the Medical Assistance Program at that time.

B. If refund of a payment as specified in Section A above is not made, the Department of Health and Mental Hygiene shall have the right to reduce its current payment to the provider by the amount of the duplicate payment, overpayment, or third party payment.

Reimbursement Methodology for Targeted Case Managment for High Risk Pregnant Recipients:

A. Request for Payment

(1) Requests for payment of Healthy Start Program services rendered and completed shall be submitted by an approved provider according to procedures established by the Department of Health and Mental Hygiene. Payment requests which are not properly prepared or submitted may not be processed, but shall be returned unpaid to the provider.

(2) Requests for payment shall be submitted on the invoice form specified by the Department of Health and Mental Hygiene. A separate invoice shall be submitted for each participant. The completed form shall indicate the:

(a) Date or dates of service;

(b) Participant's name and Medical Assistance number;

(c) Provider's name, location, and provider number; and

(d) Nature, unit or units, and procedure code or codes of covered services provided.

(3) Providers shall bill the Medical Assistance Program for the appropriate fee specified in Section C below.

B. Billing Time Limitations

(1) The Department of Health and Mental Hygiene shall not pay for claims received by the Medical Assistance Program for payment more than ~~6~~ 9 months after the completed service date.

(2) Claims for services completed on different dates and submitted on a single form shall be received by the Medical Assistance Program within ~~6~~ 9 months of the earliest completed service date.

(3) A claim which is rejected for payment due to improper completion or incomplete information shall be paid only if it is properly completed, resubmitted, and received by the Medical Assistance Program within the original ~~6~~ 9 month period, or within 60 days of rejection, whichever is later.

C. Payments shall be made:

(1) Only to a qualified provider for covered services rendered to a participant, as specified in this state plan amendment; and

(2) According to the following fee-for-service schedule for Home-Visiting Services.

Description	Fee Per Unit of Service
Home-Visiting Services	$70

Recovery and Reimbursement.

A. If the participant has insurance or if any other person is obligated either legally or contractually to pay for, or to reimburse the participant for, any services covered under these regulations, the provider shall seek payment from that source first. If payment is made by both the Medical Assistance Program and the insurance or other source, the provider shall report, within 15 days after the close of each month, on a form designated by the Department of Health and Mental Hygiene, the amount paid by the Medical Assistance Program, and the insurance or the other source, whichever is less, and refund the total amount of the lesser of the two payments reported to the Medical Assistance Program at that time.

B. If refund of a payment as specified in Section A above is not made, the Department of Health and Mental Hygiene shall have the right to reduce its current payment to the provider by the amount of the duplicate payment, overpayment, or third party payment.

Reimbursement Methodology: Hospice Care

1. The Program will pay a hospice care provider at one of four rates for each day that a participant is under the provider's care. The daily payment rates for a provider for routine home care, continuous home care, general inpatient care, and inpatient respite care will be in accordance with the amounts established by the Health Care Financing Administration (HCFA) of the U. S. Department of Health and Human Services for hospice care under a Medical Assistance Program.

2. The four daily rates are prospective rates, and there will be no retroactive adjustment other than a limitation on payments for inpatient care.

   a. During the 12-month cap period beginning November 1 of each year and ending October 31 of the following year, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed 20 percent of the aggregate total number of days of hospice care the provider furnished to Medical Assistance hospice participants during the same period.

   b. If the aggregate number of inpatient care days exceeds the maximum allowable number, the limitation on reimbursement for inpatient care will be determined in accordance with the methodology established by HCFA, and any excess reimbursement will be refunded to the Program by the provider.

   c. Any days of care furnished to participants diagnosed with Acquired Immune Deficiency Syndrome (AIDS) will be excluded in calculating the limitation on payment for inpatient care.

3. In addition to the daily rates for hospice care, the Program will make separate payment to the hospice care provider for physician services subject to the following requirements:

   (a) The services must be direct patient care services furnished to a participant under the care of the provider;

   (b) The services must be furnished by an employee of the provider or under arrangements made by the provider;

   (c) The provider must have a liability to reimburse the physician for the services rendered;

(d) No payment shall be made for physician services furnished on a volunteer basis; and

(e) Payment to the provider for physician's services shall be made in accordance with the usual Program reimbursement policy and fee schedule for physician's services contained in COMAR 10.09.02.

4. When a participant resides in a skilled nursing facility or intermediate care facility, the Program will pay an additional per diem amount for room and board to the hospice care provider on those days that the provider is reimbursed at the routine home care rate or continuous home care rate for hospice care furnished to the participant.

   a. The amount will be the per diem reimbursement established by the Program to pay for room and board in the facility;

   b. The amount will be paid only when the provider and the facility have a written agreement under which the provider is responsible for the professional management of the participant's hospice care and the facility agrees to provide room and board to the participant.

5. For participants residing in a skilled nursing facility or intermediate care facility, the Department of Human Resources shall determine the application of a recipient's resource to the cost of hospice care pursuant to COMAR 10.09.24 AND COMAR 10.09.25.

6. Requests for payment for hospice care rendered will be submitted according to procedures established by the Department. Payment requests which are not properly prepared or submitted may not be processed, but returned unpaid to the provider.

7. Requests for payment will be submitted on the invoice form specified by the Department.

Reimbursement: Obstetrical and Pediatric Services

1. **As of July 1, 1997, pediatricians, family practitioners, and certified nurse practitioners are reimbursed the lower of their customary fee or the Program's maximum fee indicated below:**

Procedure Code	Procedure Description	Upper Limit
	OFFICE AND OTHER OUTPATIENT MEDICAL SERVICES	
	New Patient	
99201	Office Visit - New Minimal	$25.00
99202	Office Visit - New Moderate	33.00
99203	Office Visit - New Extended	37.00
99204	Office Visit - New Comprehensive	48.00
99205	Office Visit - New Complicated	50.00
	Established Patient	
99211	Office Visit - Established Minimal	10.00
99212	Office Visit - Established Moderate	20.00
99213	Office Visit - Established Extended	31.00
99214	Office Visit - Established Comprehensive	38.00
99215	Office Visit - Established Complicated	45.00
	Office or Other Outpatient Consultations	
99241	Consultation - Office - Limited	33.00
99242	Consultation - Office - Intermediate	37.00
99243	Consultation - Office - Extended	43.00
99244	Consultation - Office - Comprehensive	50.00
99245	Consultation - Office - Complex	50.00
	Confirmatory Consultations	
99271	Confirmatory Consult - Limited	30.00
99272	Confirmatory Consult - Intermediate	37.00
99273	Confirmatory Consult - Extended	43.00
99274	Confirmatory Consult - Comprehensive	50.00
99275	Confirmatory Consult - Complex	50.00